STATE OF MICHIGAN
RICK SNYDER
GOVERNOR

DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
MICHIGAN ADMINISTRATIVE HEARING SYSTEM
Christopher Seppanen
Executive Director

MIKE ZIMMER
DIRECTOR

[redacted]

Date Mailed: April 1, 2016
MAHS Docket No.: 15-014914
Agency No.: [redacted]
Petitioner: [redacted]

ADMINISTRATIVE LAW JUDGE: Colleen Lack

HEARING DECISION

Following Petitioner's request for a hearing, this matter is before the undersigned Administrative Law Judge pursuant to MCL 400.9 and 400.37; 42 CFR 431.200 to 431.250; and 45 CFR 205.10. After due notice, an in-person hearing was held on February 3, 2016, from Jackson, Michigan. The Petitioner was represented by [redacted], Attorney. [redacted], the Petitioner, appeared and testified. [redacted], Mental Health Case Manager, appeared as a witness for Petitioner. The Department of Health and Human Services (Department) was represented by [redacted], Assistant Attorney General. [redacted], Family Independence Manager, and [redacted], Eligibility Specialist, appeared as a witnesses for the Department.

On August 20, 2015, Petitioner filed a hearing request. On September 16, 2015, a notice was issued showing a telephone hearing was scheduled for October 15, 2015. Petitioner's October 13, 2015, request for an in person hearing was granted. On October 14, 2015, an Adjournment Order for In Person Hearing was issued. On October 30, 2015, a notice was issued showing an in-person hearing was scheduled for December 15, 2015. On December 14, 2015, the Michigan Administrative Hearing System (MAHS) received an Appearance from Petitioner's Attorney. The parties went on the record briefly on December 15, 2015, to address a preliminary matter. The Department had been unaware that Petitioner now had an attorney. The Department's request for an adjournment to allow them to seek representation by the Attorney General's office was granted. An Adjournment Order was issued December 23, 2015. On or about January 7, 2016, MAHS received an Appearance from the Assistant Attorney General. On January 13, 2016, a notice was issued showing an in-person hearing was scheduled for February 3, 2016.

The following Exhibits were entered into the record during the February 3, 2016, hearing:

- Department's Hearing Summary Packet (Department Exhibit A, pp. 1-257), which includes:

  - Medical-Social Eligibility Certification documents (Department Exhibit A, pp. 1-9)
  - June 1, 2015, Consultative Mental Status Examination (Department Exhibit A, pp. 10-21)
  - April 20, 2015, Medical-Social Questionnaire (Department Exhibit A, pp. 22-25 and 71)
  - April 20, 2015, Authorization to Release Protected Health Information (Department Exhibit A, pp. 26-28)
  - April 20, 2015, Work History Questionnaire (Department Exhibit A, pp. 29-34 and 70)
  - April 20, 2015, Activities of Daily Living (Department Exhibit A, pp. 35-39)
  - Medical Records from [redacted] (Department Exhibit A, pp. 40-69)
  - Medical Records from [redacted] (Department Exhibit A, pp. 72-82)
  - Medical Records from [redacted] (Department Exhibit A, pp. 83-114[1])
  - Medical Records from [redacted] of [redacted] County (Department Exhibit A, pp. 115-156)
  - April 17, 2015, Medical Needs form from Dr. [redacted] (Department Exhibit A, p. 157)
  - Medical Records from [redacted] (Department Exhibit A, pp. 158-213)
  - Medical Records from [redacted] (Department Exhibit A, pp. 214-232)
  - April 28, 2015, Medical Examination Report from Dr. [redacted] (Department Exhibit A, pp. 233-235)
  - Medical Records from [redacted] (Department Exhibit A, pp. 236-248)
  - Medical Records from [redacted] (Department Exhibit A, pp. 249-257)

- Petitioner's Hearing Request (Petitioner Exhibit 1, pp. 1-2)

- Additional Medical Records Petitioner submitted prior to the February 3, 2016 hearing date (Petitioner Exhibit 2, pp. 1-101), which includes:

  - Coversheet (Petitioner Exhibit 2, p. 1)

[1] Department Exhibit A, pp. 89-90 have been removed from the record because they were medical records for someone other than Petitioner.

- Medical Records from [redacted] (Petitioner Exhibit 2, pp. 2-29)
- Medical Records from [redacted] (Petitioner Exhibit 2, pp. 30-44)
- Medical Records from [redacted] (Petitioner Exhibit 2, pp. 45-98)
- Medical Records from [redacted] (Petitioner Exhibit 2, pp. 99-101)

During the hearing, Petitioner waived the time period for the issuance of this decision, in order to allow for the submission of additional medical evidence. On February 5, 2016, an Interim Order Extending the Record was issued giving Petitioner's Representative 30 days to submit the specified additional medical records. The additional evidence was received on March 7, 2016, and has been entered into the record as Petitioner Exhibit 3, pp. 1-7, which included Medical Records from [redacted].

ISSUE

Whether the Department properly determined that Petitioner was not disabled for purposes of the Medical Assistance (MA) and/or State Disability Assistance (SDA) benefit programs?

FINDINGS OF FACT

The Administrative Law Judge, based on the competent, material, and substantial evidence on the whole record, finds as material fact:

1. On or about April 6, 2015, Petitioner applied for SDA. (Department Exhibit A, p. 1)

2. On June 16, 2015, the Department's Medical Review Team found Petitioner not disabled. (Department Exhibit A, pp. 1-3)

3. On August 20, 2015, the Department received Petitioner's timely written request for hearing. (Petitioner Exhibit 1)

4. At the time of application, Petitioner alleged disabling impairments including: knee and shoulder problems; blood clots; chronic leg pain; hematoma in belly; headaches daily; feet pain; atrial fibrillation; bone spurs in neck; and mental concentration problem. (Department Exhibit A, pp. 22-23)

5. The documentation varies regarding Petitioner's height and weight, showing Petitioner as [redacted] to [redacted] in height; and weighing [redacted]

pounds. (Department Exhibit A, pp. 13 and 233; Petitioner Exhibit 2, p. 73)

6. At the time of hearing, Petitioner was [redacted] years old with a [redacted], [redacted], birth date. (Department Exhibit A, p. 22)

7. Petitioner thinks he attended special education classes when he was younger, and did obtain a GED after being expelled from school. (Petitioner Testimony)

8. Petitioner has a work history including supervisor/operator with the [redacted] division of a [redacted] company, mechanic/laborer for a [redacted] and [redacted] company, and owner/operator of a [redacted] company. (Department Exhibit A, pp. 29-34; Petitioner Testimony)

9. Petitioner's impairments have lasted, or are expected to last, continuously for a period of 90 days or longer.

CONCLUSIONS OF LAW

Department policies are contained in the Department of Health and Human Services Bridges Administrative Manual (BAM), Department of Health and Human Services Bridges Eligibility Manual (BEM), and Department of Health and Human Services Reference Tables Manual (RFT).

The Medical Assistance (MA) program is established by Title XIX of the Social Security Act, 42 USC 1396-1396w-5; 42 USC 1315; the Affordable Care Act of 2010, the collective term for the Patient Protection and Affordable Care Act, Pub. L. No. 111-148, as amended by the Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152; and 42 CFR 430.10-.25. The Department (formerly known as the Department of Human Services) administers the MA program pursuant to 42 CFR 435, MCL 400.10, and MCL 400.105-.112k.

The State Disability Assistance (SDA) program, which provides financial assistance for disabled persons, was established by 2004 PA 344. The Department administers the SDA program pursuant to 42 CFR 435, MCL 400.10 *et seq.* and Mich Admin Code, Rules 400.3151 – 400.3180. A person is considered disabled for SDA purposes if the person has a physical or mental impairment which meets federal Supplemental Security Income (SSI) disability standards for at least ninety days. Receipt of SSI benefits based on disability or blindness, or the receipt of MA benefits based on disability or blindness, automatically qualifies an individual as disabled for purposes of the SDA program.

Disability is defined as the inability to do any substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected to result in death or which has lasted or can be expected to last for a continuous period of not

less than 12 months. 20 CFR 416.905(a). The person claiming a physical or mental disability has the burden to establish it through the use of competent medical evidence from qualified medical sources such as his or her medical history, clinical/laboratory findings, diagnosis/prescribed treatment, prognosis for recovery and/or medical assessment of ability to do work-related activities or ability to reason and make appropriate mental adjustments, if a mental disability is alleged. 20 CFR 416.913. An individual's subjective pain complaints are not, in and of themselves, sufficient to establish disability. 20 CFR 416.908; 20 CFR 416.929(a). Similarly, conclusory statements by a physician or mental health professional that an individual is disabled or blind, absent supporting medical evidence, is insufficient to establish disability. 20 CFR 416.927.

When determining disability, the federal regulations require several factors to be considered including: (1) the location/duration/frequency/intensity of an applicant's pain; (2) the type/dosage/effectiveness/side effects of any medication the applicant takes to relieve pain; (3) any treatment other than pain medication that the applicant has received to relieve pain; and (4) the effect of the applicant's pain on his or her ability to do basic work activities. 20 CFR 416.929(c)(3). The applicant's pain must be assessed to determine the extent of his or her functional limitation(s) in light of the objective medical evidence presented. 20 CFR 416.929(c)(2).

In order to determine whether or not an individual is disabled, federal regulations require a five-step sequential evaluation process be utilized. 20 CFR 416.920(a)(1). The five-step analysis requires the trier of fact to consider an individual's current work activity; the severity of the impairment(s) both in duration and whether it meets or equals a listed impairment in Appendix 1; residual functional capacity to determine whether an individual can perform past relevant work; and residual functional capacity along with vocational factors (i.e. age, education, and work experience) to determine if an individual can adjust to other work. 20 CFR 416.920(a)(4); 20 CFR 416.945.

If an individual is found disabled, or not disabled, at any step, a determination or decision is made with no need evaluate subsequent steps. 20 CFR 416.920(a)(4). If a determination cannot be made that an individual is disabled, or not disabled, at a particular step, the next step is required. 20 CFR 416.920(a)(4). If an impairment does not meet or equal a listed impairment, an individual's residual functional capacity is assessed before moving from step three to step four. 20 CFR 416.920(a)(4); 20 CFR 416.945. Residual functional capacity is the most an individual can do despite the limitations based on all relevant evidence. 20 CFR 416.945(a)(1). An individual's residual functional capacity assessment is evaluated at both steps four and five. 20 CFR 416.920(a)(4). In determining disability, an individual's functional capacity to perform basic work activities is evaluated and if found that the individual has the ability to perform basic work activities without significant limitation, disability will not be found. 20 CFR 416.994(b)(1)(iv). In general, the individual has the responsibility to prove disability. 20 CFR 416.912(a). An impairment or combination of impairments is not severe if it does not significantly limit an individual's physical or mental ability to do

basic work activities. 20 CFR 416.921(a). The individual has the responsibility to provide evidence of prior work experience; efforts to work; and any other factor showing how the impairment affects the ability to work. 20 CFR 416.912(c)(3)(5)(6).

As outlined above, the first step looks at the individual's current work activity. In the record presented, the Petitioner is not involved in substantial gainful activity. Therefore, Petitioner is not ineligible for disability benefits under Step 1.

The severity of the Petitioner's alleged impairment(s) is considered under Step 2. The Petitioner bears the burden to present sufficient objective medical evidence to substantiate the alleged disabling impairments. In order to be considered disabled for MA purposes, the impairment must be severe. 20 CFR 416.920(a)(4)(ii); 20 CFR 416.920(b). An impairment, or combination of impairments, is severe if it significantly limits an individual's physical or mental ability to do basic work activities regardless of age, education and work experience. 20 CFR 416.920(a)(4)(ii); 20 CFR 416.920(c). Basic work activities means the abilities and aptitudes necessary to do most jobs. 20 CFR 416.921(b). Examples include:

1. Physical functions such as walking, standing, sitting, lifting, pushing, pulling, reaching, carrying, or handling;

2. Capacities for seeing, hearing, and speaking;

3. Understanding, carrying out, and remembering simple instructions;

4. Use of judgment;

5. Responding appropriately to supervision, co-workers and usual work situations; and

6. Dealing with changes in a routine work setting.

Id.

The second step allows for dismissal of a disability claim obviously lacking in medical merit. *Higgs v Bowen,* 880 F2d 860, 862 (CA 6, 1988). The severity requirement may still be employed as an administrative convenience to screen out claims that are totally groundless solely from a medical standpoint. *Id.* at 863 *citing Farris v Sec of Health and Human Services,* 773 F2d 85, 90 n.1 (CA 6, 1985). An impairment qualifies as non-severe only if, regardless of a Petitioner's age, education, or work experience, the impairment would not affect the Petitioner's ability to work. *Salmi v Sec of Health and Human Services,* 774 F2d 685, 692 (CA 6, 1985).

At the time of application, Petitioner alleged disabling impairments including: knee and shoulder problems; blood clots; chronic leg pain; hematoma in belly; headaches daily; feet pain; atrial fibrillation; bone spurs in neck; and mental concentration problem. (Department Exhibit A, pp. 22-23)

While some older medical records were included, this analysis will focus on the more recent medical evidence.

On [redacted], Petitioner was treated in the emergency department for a sprained left knee. Chronic shoulder pain was also noted. (Department Exhibit A, pp. 55-65) A [redacted], MRI of the left knee documented findings including non-displaced trabecular fractures, partial ACL tear, and patellar chondromalacia. (Department Exhibit A, pp. 66-67) A [redacted], MRI of the right upper extremity documented findings including older lesion consistent with prior dislocation injury and surgical repair, partial subscapularis tear, severe glenohumeral osteoarthritis, posterior labral tear, and AC joint osteoarthritis. (Department Exhibit A, pp. 68-69)

January 2015 records from [redacted] document active diagnoses of mood disorder and cannabis abuse, as well as rule out diagnoses of bipolar disorder and personality disorder. Petitioner's Global Assessment of Functioning (GAF) was 40 on [redacted]. (Department Exhibit A, pp. 158-206)

January and February 2015 records from [redacted] document diagnosis and treatment of chronic anal fissure. (Department Exhibit A, pp. 214-226)

Petitioner was hospitalized [redacted], for appendicitis. (Department Exhibit A, pp. 115-156) It was noted that Petitioner had recurrent DVT and the medication for this was withheld for two days before the appendectomy was performed. Petitioner was then treated for post-operative intra-abdominal bleed and transferred to another hospital. Additional diagnoses included paroxysmal atrial fibrillation and precipitous blood loss. (Department Exhibit A, p. 123)

Petitioner was hospitalized [redacted]. (Department Exhibit A, pp. 236-242) Discharge diagnoses included: acute blood loss anemia secondary to intra abdominal and abdominal wall hematoma; status post fall x2 at prior hospital; history of left leg deep venous thrombosis (DVT) of the left leg; paroxysmal atrial fibrillation; hypokalemia; hepatitis C; neck, shoulder and right knee pain secondary to the fall; history of major depression and questionable suicidal ideation; severe constipation exacerbated by narcotic use; and intractable pain in abdomen and back improved by discharge. (Department Exhibit A, pp. 239) A filter was placed in Petitioner's inferior vena cava. (Petitioner Exhibit 2, pp. 100-101)

Petitioner was hospitalized [redacted], to [redacted], for: DVT of the right leg below knee; history of paroxysmal atrial fibrillation; severe osteoarthritis with chronic lower back pain; history of hepatitis C; and previous history of DVT. (Department Exhibit A, pp. 244-248)

A [redacted], Neurosurgery Consultation for complaints of pain in both lower extremities noted left leg DVT, abdominal wall hematoma found subsequent to appendectomy, and history of atrial fibrillation. It was noted that an MRI showed mild spondylitic changes of the lumbar spine and a tiny bulge in the proximal neural foramen at L4-L5 on the left touching L4 nerve. However, Petitioner's main complaints of pain were on the right side and there was no evidence of any right lower extremity nerve root compression where he has pain. It was thought that the pain could be from the vascular problems Petitioner has or muscular pain. (Department Exhibit A, pp. 78-82)

March and April 2015, records from [redacted] documented diagnosis and treatment for chronic lower leg DVT, abdominal wall hematoma, chronic atrial fibrillation, hepatitis C, and chronic pain bilateral shoulders and knees. (Department Exhibit A, pp. 83-88 and 91-114)

April 2015 records from [redacted] document multiple problems, including right pelvic hematoma, knee pain with straight leg extension and compensated gait, chronic cervical spondylosis. (Department Exhibit A, pp. 72-77)

April 2015 records from [redacted] document diagnosis and treatment of atrial fibrillation, DVT, and venous insufficiency. Other noted problems included anal fissure, back pain, knee pain, and labrum shoulder tear. (Department Exhibit A, pp. 250-256)

An April 17, 2015, Medical Needs form completed by Dr. [redacted] documents diagnoses of chronic low back pain, chronic DVT, and chronic knee pain. The doctor certified that Petitioner had a medical need for assistance with listed personal care activities. The doctor also marked that Petitioner would be unable to work at his usual occupation or any job for 6 months. (Department Exhibit A, p. 157)

An April 28, 2015, Medical Examination Report from Dr. [redacted] documents diagnoses of lumbago and knee pain. The doctor marked that Petitioner's physical limitations were expected to last more than 90 days, which included: lifting less than 10 pounds occasionally and never 10 pounds or more; stand/walk less than 6 hours in an 8 hour work day; sit less than 6 hours in an 8 hour work day; and unable to operate foot/leg controls. (Department Exhibit A, pp. 233-235)

On [redacted], Petitioner attended a consultative Mental Status Examination. (Department Exhibit A, pp. 10-21) Diagnoses were adjustment disorder with depression, insomnia disorder, other specified disruptive impulse control and conduct disorder, and mild cannabis use disorder. The psychologist noted that he could not get a good reading of Petitioner's mental health and indicated this was due to Petitioner not wanting to accept/denying mental health problems and wanting to focus on his physical health. (Department Exhibit A, p. 20)

June through September 2015, records from [redacted] document active diagnoses of moderate recurrent major depressive disorder and

cannabis abuse. Personality disorder continued to be listed as a rule out diagnosis. (Petitioner Exhibit 2, pp. 2-29)

On [redacted], Petitioner was seen for dysphagia that began 2 months prior. (Petitioner Exhibit 2, pp. 40-44) On [redacted], Petitioner underwent esophagogastroduodenoscopy and biopsy of samples from the stomach antrum and gastroesophageal junction. Postoperative diagnoses were dysphagia and small hiatal hernia. (Petitioner Exhibit 2, pp. 35-39)

An [redacted] right shoulder arthrogram documented findings including: mild hypertrophy of the AC joint, a small bone ossicle within the superior aspect of the AC joint, and no evidence of rotator cuff tear. (Petitioner Exhibit 2, pp. 31-32) An [redacted], MR right shoulder arthrogram documented findings including: glenohumeral joint arthritis, torn anterior superior labrum, and AC joint degeneration. (Petitioner Exhibit 2, pp. 33-34)

April 2015 through December 2015 records from Dr. [redacted] document diagnosis and treatment of multiple conditions, including: chronic pain, lower leg DVT, lower leg joint pain, lumbago, atrial fibrillation, hand numbness, abdominal pain, cervical spondylosis, medial meniscus tear, memory deficiency, chronic venous insufficiency, chronic bilateral knee pain, chronic shoulder pain (right greater than left and needs surgery on right shoulder), chronic embolism and thrombosis of unspecified deep veins of distal lower extremity, and hepatitis C. (Petitioner Exhibit 2, pp. 46-98) A [redacted], MR of the right knee showed radial tear involving medial meniscus suspected, grade IV chondromalacia patella with delamination of lateral patellar cartilage, and bone marrow signal abnormality of the medial tibial metaphysis that may be due to bone marrow contusion. (Petitioner Exhibit 2, pp. 58-59) The records from Dr. [redacted] also note that Petitioner is unable to have knee surgery as cardiology is unable to clear him due to high risk of DVT formation. (Petitioner Exhibit 2, p. 74) Copies of the records from cardiology and orthopedic providers Petitioner was referred to were also included by Dr. [redacted]. The records from the orthopedic provider document medial meniscus tear and rotator cuff tendonitis. (Petitioner Exhibit 2, pp. 77-91) An October 20, 2015, Physical Medical Source Statement from Dr. [redacted] lists diagnoses of DVT, back pain, knee pain, shoulder pain, chronic venous insufficiency, atrial fibrillation, and hepatitis C. It was marked that Petitioner's impairments have lasted or were expected to last 12 months. The marked limitations included sitting about 2 hours total in an 8 hour work day, standing/walking less than 2 hours in an 8 hour work day, as well as a need to shift positions at will and take unscheduled breaks. It was marked that Petitioner would likely be off task 25% or more of a typical work day and would be capable of low stress work. (Petitioner Exhibit 2, pp. 92-94)

A November 24, 2015, Medication Review Note from [redacted] documented active diagnoses including: adjustment disorder, mild cannabis use disorder, chronic hepatitis C, low back pain, and bilateral primary osteoarthritis of the knee. The co-occurring consumer quadrant note indicates more severe mental disorder/less severe substance disorder. It was noted that Petitioner's symptoms were

significantly less severe and counseling was recommended. (Petitioner Exhibit 3, pp. 3 - 7)

As previously noted, Petitioner bears the burden to present sufficient objective medical evidence to substantiate the alleged disabling impairment(s). As summarized above, Petitioner has presented medical evidence establishing that he does have limitations on the ability to perform basic work activities. The medical evidence has established that the Petitioner has an impairment, or combination thereof, that has more than a de minimis effect on the Petitioner's basic work activities. Further, the impairments have lasted, or can be expected to last, continuously for 90 days; therefore, the Petitioner is not disqualified from receipt of SDA benefits under Step 2.

In the third step of the sequential analysis of a disability claim, the trier of fact must determine if the Petitioner's impairment, or combination of impairments, is listed in Appendix 1 of Subpart P of 20 CFR, Part 404. The evidence confirms diagnosis and treatment of multiple impairments including: chronic anal fissure, DVT, chronic venous insufficiency, atrial fibrillation, osteoarthritis, back pain, chronic pain bilateral shoulders and knees, shoulder labrum tear, rotator cuff tendonitis, medial meniscus tear, chronic cervical spondylosis, hepatitis C, dysphagia, depression, mood disorder, and adjustment disorder.

Based on the objective medical evidence, considered listings included: 1.00 Musculoskeletal System, 4.00 Cardiovascular System, 7.00 Hematological Disorders, 12.00 Mental Disorders. However, the medical evidence was not sufficient to meet the intent and severity requirements of any listing, or its equivalent. Accordingly, the Petitioner cannot be found disabled, or not disabled, at Step 3 based on the objective medical evidence available; therefore, the Petitioner's eligibility is considered under Step 4. 20 CFR 416.905(a).

Before considering the fourth step in the sequential analysis, a determination of the individual's residual functional capacity ("RFC") is made. 20 CFR 416.945. An individual's RFC is the most he/she can still do on a sustained basis despite the limitations from the impairment(s). *Id.* The total limiting effects of all the impairments, to include those that are not severe, are considered. 20 CFR 416.945(e).

To determine the physical demands (exertional requirements) of work in the national economy, jobs are classified as sedentary, light, medium, heavy, and very heavy. 20 CFR 416.967. Sedentary work involves lifting of no more than 10 pounds at a time and occasionally lifting or carrying articles like docket files, ledgers, and small tools. 20 CFR 416.967(a). Although a sedentary job is defined as one which involves sitting, a certain amount of walking and standing is often necessary in carrying out job duties. *Id.* Jobs are sedentary if walking and standing are required occasionally and other sedentary criteria are met. Light work involves lifting no more than 20 pounds at a time with frequent lifting or carrying objects weighing up to 10 pounds. 20 CFR 416.967(b). Even though weight lifted may be very little, a job is in this category when it requires a

good deal of walking or standing, or when it involves sitting most of the time with some pushing and pulling of arm or leg controls. *Id.* To be considered capable of performing a full or wide range of light work, an individual must have the ability to do substantially all of these activities. *Id.* An individual capable of light work is also capable of sedentary work, unless there are additionally limiting factors such as loss of fine dexterity or inability to sit for long periods of time. *Id*. Medium work involves lifting no more than 50 pounds at a time with frequent lifting or carrying of objects weighing up to 25 pounds. 20 CFR 416.967(c). An individual capable of performing medium work is also capable of light and sedentary work. *Id.* Heavy work involves lifting no more than 100 pounds at a time with frequent lifting or carrying of objects weighing up to 50 pounds. 20 CFR 416.967(d). An individual capable of heavy work is also capable of medium, light, and sedentary work. *Id.* Finally, very heavy work involves lifting objects weighing more than 100 pounds at a time with frequent lifting or carrying objects weighing 50 pounds or more. 20 CFR 416.967(e). An individual capable of very heavy work is able to perform work under all categories. *Id.*

Limitations or restrictions which affect the ability to meet the demands of jobs other than strength demands (exertional requirements, i.e. sitting, standing, walking, lifting, carrying, pushing, or pulling) are considered nonexertional. 20 CFR 416.969a(a). In considering whether an individual can perform past relevant work, a comparison of the individual's residual functional capacity with the demands of past relevant work. *Id.* If an individual can no longer do past relevant work the same residual functional capacity assessment along with an individual's age, education, and work experience is considered to determine whether an individual can adjust to other work which exists in the national economy. *Id.* Examples of non-exertional limitations or restrictions include difficulty to function due to nervousness, anxiousness, or depression; difficulty maintaining attention or concentration; difficulty understanding or remembering detailed instructions; difficulty in seeing or hearing; difficulty tolerating some physical feature(s) of certain work settings (i.e. can't tolerate dust or fumes); or difficulty performing the manipulative or postural functions of some work such as reaching, handling, stooping, climbing, crawling, or crouching. 20 CFR 416.969a(c)(1)(i) – (vi). If the impairment(s) and related symptoms, such as pain, only affect the ability to perform the non-exertional aspects of work-related activities, the rules in Appendix 2 do not direct factual conclusions of disabled or not disabled. 20 CFR 416.969a(c)(2). The determination of whether disability exists is based upon the principles in the appropriate sections of the regulations, giving consideration to the rules for specific case situations in Appendix 2. *Id.*

The evidence confirms diagnosis and treatment of multiple impairments including: chronic anal fissure, DVT, chronic venous insufficiency, atrial fibrillation, osteoarthritis, back pain, chronic pain bilateral shoulders and knees, shoulder labrum tear, rotator cuff tendonitis, medial meniscus tear, chronic cervical spondylosis, hepatitis C, dysphagia, depression, mood disorder, and adjustment disorder. Petitioner's testimony indicated that he could not sit or stand for sufficient time periods to meet the requirements of even sedentary level work. Petitioner also testified he is afraid to have needed surgery for his

knees due to the risks of blood clots. Petitioner described his symptoms, including pain, difficulty bending, trouble sleeping, anger outbursts, and trouble concentrating. Overall, Petitioner's testimony was mostly consistent with the medical records. Further, the opinion of the treating physician, Dr. [redacted], indicated physical limitations that would preclude performing the full range of sedentary level work on the April 28, 2015, Medical Examination Report and October 20, 2015, Physical Medical Source Statement. (Department Exhibit A, pp. 233-235; Petitioner Exhibit 2, pp. 92-94)

This treating physician's opinion is supported by the medical records and is given controlling weight. After review of the entire record it is found, at this point, that Petitioner does not maintain the residual functional capacity to perform sedentary work as defined by 20 CFR 416.967(a) on a sustained basis.

The fourth step in analyzing a disability claim requires an assessment of the Petitioner's residual functional capacity ("RFC") and past relevant employment. 20 CFR 416.920(a)(4)(iv). An individual is not disabled if he/she can perform past relevant work. *Id*.; 20 CFR 416.960(b)(3). Past relevant work is work that has been performed within the past 15 years that was a substantial gainful activity and that lasted long enough for the individual to learn the position. 20 CFR 416.960(b)(1). Vocational factors of age, education, and work experience, and whether the past relevant employment exists in significant numbers in the national economy is considered. 20 CFR 416.960(b)(3).

Petitioner has a work history including supervisor/operator with the [redacted] division of a [redacted] company, mechanic/laborer for a [redacted] and [redacted] company, and owner/operator of a [redacted] company. (Department Exhibit A, pp. 29-34; Petitioner Testimony) In light of the entire record and Petitioner's RFC (see above), it is found that Petitioner is not able to perform his past relevant work. Accordingly, the Petitioner cannot be found disabled, or not disabled, at Step 4; therefore, the Petitioner's eligibility is considered under Step 5. 20 CFR 416.905(a).

In Step 5, an assessment of Petitioner's residual functional capacity and age, education, and work experience is considered to determine whether an adjustment to other work can be made. 20 CFR 416.920(4)(v). At the time of hearing, Petitioner was [redacted] years old and, thus, considered to be a younger individual for disability purposes. Petitioner completed a GED and has a work history including supervisor/operator with the [redacted] of a [redacted] company, mechanic/laborer for a [redacted] and [redacted] company, and owner/operator of a [redacted] company. Disability is found if an individual is unable to adjust to other work. *Id.* At this point in the analysis, the burden shifts from the Petitioner to the Department to present proof that the Petitioner has the residual capacity to substantial gainful employment. 20 CFR 416.960(2); *Richardson v Sec of Health and Human Services*, 735 F2d 962, 964 (CA 6, 1984). While a vocational expert is not required, a finding supported by substantial evidence that the individual has the vocational qualifications to perform specific jobs is needed to meet the burden. *O'Banner v Sec of Health and Human Services*, 587 F2d 321, 323 (CA 6, 1978). Medical-Vocational guidelines found at 20 CFR Subpart P, Appendix II, may be used to

satisfy the burden of proving that the individual can perform specific jobs in the national economy. *Heckler v Campbell*, 461 US 458, 467 (1983); *Kirk v Secretary*, 667 F2d 524, 529 (CA 6, 1981) *cert den* 461 US 957 (1983).

The evidence confirms diagnosis and treatment of multiple impairments including: chronic anal fissure, DVT, chronic venous insufficiency, atrial fibrillation, osteoarthritis, back pain, chronic pain bilateral shoulders and knees, shoulder labrum tear, rotator cuff tendonitis, medial meniscus tear, chronic cervical spondylosis, hepatitis C, dysphagia, depression, mood disorder, and adjustment disorder. As noted above, Petitioner does not maintain the residual functional capacity to perform sedentary work as defined by 20 CFR 416.967(a) on a sustained basis.

After review of the entire record, and in consideration of the Petitioner's age, education, work experience, RFC, and using the Medical-Vocational Guidelines [20 CFR 404, Subpart P, Appendix II] as a guide, Petitioner is found disabled at Step 5.

In this case, the Petitioner is found disabled for purposes SDA benefits as the objective medical evidence establishes a physical or mental impairment that met the federal SSI disabiltiy standard with the shortened duration of 90 days. In light of the foregoing, it is found that Petitioner's impairments did preclude work at the above stated level for at least 90 days.

The Administrative Law Judge, based on the above Findings of Fact and Conclusions of Law, and for the reasons stated on the record, if any, finds Petitioner disabled for purposes of the SDA benefit program.

DECISION AND ORDER

Accordingly, the Department's determination is **REVERSED**.

THE DEPARTMENT IS ORDERED TO INITIATE THE FOLLOWING, IN ACCORDANCE WITH DEPARTMENT POLICY AND CONSISTENT WITH THIS HEARING DECISION, WITHIN 10 DAYS OF THE DATE THE ORDER WAS ISSUED:

1. Initiate a review of the application dated April 6, 2015, for SDA, if not done previously, to determine Petitioner's non-medical eligibility. The Department shall inform Petitioner of the determination in writing. A review of this case shall be set for August 2016.

2. The Department shall supplement for lost benefits (if any) that Petitioner was entitled to receive, if otherwise eligible and qualified in accordance with Department policy.

Colleen Lack

CL/mc

Colleen Lack
Administrative Law Judge
for Nick Lyon, Director
Department of Health and Human Services

NOTICE OF APPEAL: A party may appeal this Order in circuit court within 30 days of the receipt date. A copy of the circuit court appeal must be filed with the Michigan Administrative Hearing System (MAHS).

A party may request a rehearing or reconsideration of this Order if the request is received by MAHS within 30 days of the date the Order was issued. The party requesting a rehearing or reconsideration must provide the specific reasons for the request. MAHS will not review any response to a request for rehearing/reconsideration.

A written request may be mailed or faxed to MAHS. If submitted by fax, the written request must be faxed to (517) 335-6088; Attention: MAHS Rehearing/Reconsideration Request.

If submitted by mail, the written request must be addressed as follows:

Michigan Administrative Hearings
Reconsideration/Rehearing Request
P.O. Box 30639
Lansing, Michigan 48909-8139

DHHS

[redacted]

Counsel for Respondent

[redacted]

Petitioner

[redacted]

Counsel for Complainant

[redacted]